Interdisciplinary Team Curriculum: Providing Integrated Consumer Centered Care

This curriculum, was developed based on the quality research findings related to creating an interdisciplinary care team (1996). Module I of the curriculum is designed to assist team members in understanding discipline specific attitutudes, priorities, and expertise, highlghting the similarities and differences among the professionals on the team, and how professional identification can affect interdisciplinary approaches to practice. Module II is designed to explore how health and long term care providers conceptualize consumer centered practice differently, increase appreciation for these differences, and demonstrate how these differences can be used in care planning for the benefit of the consumer.

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Acknowledgments:

The authors wish to thank the following organizations for their support and assistance in the development of this curriculum:

The Robert Wood Johnson Foundation

The State of Wisconsin, Department of Health and Family Services

ElderCare of Dane County, Madison, WI

Access to Independence & Community Living Alliance, Madison, WI

Community Care for the Elderly, Milwaukee, WI

Community Health Partnership, Eau Claire, WI

Academy for Quality in Comprehensive Community Care, Madison, WI

Partners for Community Services, Inc., Madison, WI

University of Wisconsin-Madison, School of Nursing

University of Wisconsin-Madison, School of Education, Department of Counseling Psychology

Wisconsin Partnership Mission

*The **Wisconsin Partnership Program** will maximize the ability of members to live in the setting of their choice, to participate in community life, and to be engaged in the decision-making processes regarding their own care.*

The Wisconsin Partnership Program will ensure that members receive high quality health care and other supports necessary to be valued citizens in the community.

***Partnership** will:*

- Assure service delivery and care coordination through an interdisciplinary team which will include the member, Nurse Practitioner, Social Worker/Service Coordinator, R.N., and Primary Care Physician;
- Provide services which will treat its members as dignified individuals who have responsibilities as well as rights;
- Allow members to manage their own services to the greatest extent possible;
- Provide the information necessary for members to make informed decisions;
- Offer quality services on a timely basis that are both member and provider friendly;
- Improve the attitudes and practices of the health care profession toward frail elderly and people with physical disabilities;
- Maintain physical and mental health standards to assure optimal levels of health and functioning for members;
- Support members in developing and maintaining friendships and in participating with their families;
- Flexibly adapt services as necessary to meet the changing needs of individual members;
- Emphasize member citizenship, self-reliance and sense of self-worth;
- Ensure that public and private resources are utilized effectively and equitably to carry out the individual's service

The Wisconsin Partnership Program

The Wisconsin Partnership Program is a comprehensive program of services for people in Wisconsin who are elderly or disabled. The program integrates health and long term support services, including home and community-based services, physician services, and all other medical care. The goals of the Partnership Program are to:

- Reduce fragmentation and inefficiency within and between health care and long term support delivery systems,
- Improve quality of health and long term care while containing costs, and
- Increase the ability of people to participate in decisions regarding their own health care and to live in the community.

The Partnership Program has team-based service coordination at its center. The member, his or her physician, and a team of nurses and social workers develop a care plan together. Partnership Program services are delivered in the member's home or in a setting of his or her choice.

Team-based Service Coordination: The Interdisciplinary Care Team (IDT)

In order to integrate the delivery of health and long term care, from its inception the Wisconsin Partnership Program has incorporated an interdisciplinary team into the Program design. The success of the Program is reliant upon the successful communication and functioning of the interdisciplinary team.

Effective practice of the interdisciplinary team depends on having team members who understand, appreciate, and collaborate with other disciplines and providers. Rather than dividing care decisions by discipline or setting, the team members must collaborate with one another, *and with the member*, when making decisions about services. In order to do this effectively, team members need to have a thorough understanding of their own profession, how their varied experiences impact the way they provide care, and how team members approaches to practice can be integrated for the benefit of the consumer. Team members must also be able to identify, and integrate into their practice, those aspects of care and service delivery that are most important to the consumers they serve. Each decision, plan of care, and individual service plan should reflect the combined expertise of team members and the individual enrolled in the program.

Each member of the team should participate actively in the care planning process. Involving members (consumers) of the Partnership Program in decision making is not the same as simply teaching or gaining their cooperation. The Partnership Program is committed to including the member and family as real partners in both planning and evaluating the care.

The Origin and Purpose of the IDT Curriculum Workshop

The curriculum was developed based on research findings from interviews with frail elderly consumers, consumers with physical disabilities and chronic illnesses, and health and long term care providers. The interviews focused on subjects' experiences providing and receiving care, and specifically, what aspects of care delivery were most important to their evaluations of the quality of the care. In general, the findings indicated that health care providers tended to rely on clinical process or outcome measures to determine the quality of care. In contrast, social workers tended to generally rely on their success in achieving or meeting consumer identified choices or preferences. Consumers tended to assume that *both* clinical outcomes and their preferences are integrated into high quality care. Clearly, both provider perspectives and expertise are necessary to deliver what the consumer perceives to be quality care.

In order to provide this care effectively, we believe providers need to first have a thorough understanding of their own profession, how their discipline specific priorities affect the way they provide care, and how these different approaches to practice can be integrated for the benefit of the consumers they serve. In addition, we believe it is critically important that team members be able to identify, and integrate into their practice, those aspects of care and service delivery that are most important to consumers. *Each decision, plan of care, and individual member service plan should reflect the combined expertise of team members, including the consumer being served.*

The purpose of this IDT curriculum workshop is to assist team members to discuss and explore how to provide collaborative, consumer centered care in integrated care settings. Curriculum objectives include: 1) assisting providers to understand their work as a representative of a particular professional discipline; 2) provide opportunities to share discipline specific knowledge with colleagues in the same, or other, disciplines; 3) explore how different professionals define, provide, and evaluate consumer centered care; and, 4) increase awareness about the values and expertise that consumers have, and integrate that expertise into team decisionmaking.

Specific workshop objectives for a particular organization should be determined with that organization's management staff prior to the curriculum workshop being conducted.

Depending on the level and experience of the participants in the workshop, it may be necessary to shorten, lengthen, or otherwise adapt the modules, move within and among the different exercises in each module, or eliminate an exercise in a module altogether. "Instructor's Notes" are included in the text of this handbook to provide specific information to the instructor about the exercises that follow.

Workshop Instructors

This curriculum was designed to be conducted by an instructor with professional experience and knowledge in human relations and group dynamics. The instructor should also have expertise about the Partnership Program history and development, and the Partnership Quality Research findings[i]. Additionally, the instructor should be familiar with and understand the Partnership Mission and the roles of Interdisciplinary Team

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[i] **Quality Care from the Perspective of Elderly Consumers, 1996** Narrative report of findings based on analysis of interviews with elderly consumers in WI. Subjects include individuals enrolled in PACE and WPP programs at ElderCare of Dane County, as well as those living independently in the community.

Quality Care from the Perspective of Consumers with Physical Disabilities and their Caregivers, 1996
Narrative report of findings based on analysis of interviews with individuals with physical disabilities and their caregivers about care experiences.

Interdisciplinary Team Model, 1996
Narrative report describing the planning, initial development, and evolution of the interdisciplinary care team model in the Partnership Program. Includes identification of the complexities involved in providing consumer-centered care in an integrated (health and long term) care setting.

Model Quality Improvement Reviews, 1997
Designed for use by Partnership sites serving frail elderly and physically disabled populations, these Reviews provide information to organizations about specific areas of care and service delivery (system level and direct service level) identified by BOTH providers and consumers as important to quality of care and quality of life. Specific review areas include: Integrating Consumer Preferences into Plans of Care, Personal Care Services, Transportation Services, and Monitoring Medication Profiles.
4a. Quality Research Team's Consultation with Partnership Sites, 1997 *Report outlining Model QI Review plans at three Partnership Sites*
4b. Quality Research Team's Review of Model QI Studies Conducted at Partnership Sites, 1998 *Report outlining three Partnership site studies, significant findings, and recommendations for future studies. (Individual Partnership site reports are included)*

Member Evaluation, 1998
T*his research based evaluation* was *designed for use* by members (consumers) enrolled in integrated care programs *to evaluate* quality. *Evaluation areas, identified by* both *consumers and* health and long term care *providers, correspond to quality care/service areas outlined in* the *Model Q*uality *I*mprovement *Reviews (see above).*

members[ii]. This expertise is necessary to achieve the teaching objectives identified in each of the curriculum modules. A basic understanding of group dynamics within a workshop setting is also necessary to select the appropriate focus and level of each module and to manage individual and group responses to challenging materials.

Participant Audience – Team Members

It is extremely important that the curriculum instructor have a clear sense of the level of experience of the team members in the workshop. Assessments prior to and during the workshop are necessary to distinguish levels of experience (see page 8 for suggested pre-workshop assessment activity). Discussions with management staff should also assist in identifying the level of a team's experience with integrated practice. It is important that the workshop participants also be 'balanced', in terms of the number of professionals from each discipline participating in any one workshop. The Partnership team model requires a registered nurse, a nurse practitioner and a social worker/social services coordinator – having three teams participate in a single workshop will result in 6 nursing staff and 3 social work staff. Try to ensure that workshop audiences include a balanced number of professionals from each discipline by inviting additional team members as needed.

Most workshop participants will include practitioners with little or no clinical experience working with Partnership populations or in integrated (acute and long-term) care settings. You may also have practitioners with 1) significant clinical experience, but no interdisciplinary team experience, or 2) practitioners with interdisciplinary team experience, but the experience has been on teams lacking high levels of integration among members. In some rare instances, you may have groups made up of experienced practitioners who meet all of the criteria mentioned above (i.e., clinical experience working in integrated care settings with Partnership populations and interdisciplinary team experience where members experienced a high level of integration). In each of these situations, the curriculum structure may need to be adjusted accordingly.

[ii] Wisconsin Partnership Program Protocol Manual, Part 1 – Site Operations, Revised May, 1998.

Assessment Activity - Professional Identification[iii]

Part I of II:

Each of us has particular ideas about why people end up practicing in the professions that they do. Our thinking may be based on stereotypes, and can be exaggerated, but our impressions and perspectives about professionals in our own practice, and in other practices, can impact the way we interact with others on daily basis.

For each of the professionals listed below, please list some of the things that you think might motivate an individual to become a member of that profession. Think about and note the different skills you think individuals in these professions need to have in order to be successful in their work. Please be as specific and detailed as you can be about each profession. Use the back of this sheet if you need more room.

Physician

Registered Nurse

Personal Care Worker/Daily Living Attendant

Licensed Practical Nurse

Nurse Practitioner

Social Worker/Social Services Coordinator

[iii] Adapted from Interdisciplinary Collaborative Teams in Primary Care' handbook, Pew Health Professions Commission, 1997.

Part II of II

"Client/Patient/Consumer centered care" "Consumer responsive care"…these are terms we often hear used by health and long term care professionals. Have you heard these terms before? How would you describe/define what these mean? What does it mean to practice in a "consumer centered way? Please provide as much detail as you can. Share an example if you like:

Could you please identify yourself by your profession/discipline (NP, RN, LPN, SW) ONLY here:

Could you please identify 3 previous work settings (hospital, home care, nursing home, etc…) you have worked in, and the approximate length of time you worked in each:

Setting	**Length of time**
1.	
2.	
3.	

Thank you very much!! Please mail this completed form in the postage paid envelope provided, or mail/fax to:

(Insert Instructor Contact Information Here)

Curriculum Outline*

Module I: Team Member Professional Identification and Cross Discipline Awareness

Day One

- Professional Self-Knowledge
- Sharing Self-Knowledge

Day Two

- Cross Discipline Awareness

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***[Note:** Module I is currently formatted as a 2 day workshop]*

"For true collaboration to occur, it was necessary to move from the starting point of conflicting viewpoints, through tolerance, and on to a real appreciation of what each discipline had to offer the other, and together, what they could provide to the member."

Interdisciplinary Team Model
Wisconsin Partnership Program, Quality Research, 1996

Day One

Part I.

Professional
Self-Knowledge

Instructor Note: The following Quality Research narratives, developed by the Partnership Quality Research team, should be read by the Workshop Instructor prior to conducting this Module:

Quality Care from the Perspective of Elderly Consumers, 1996
Narrative report of findings based on analysis of interviews with elderly consumers in WI.

Quality Care from the Perspective of Consumers with Physical Disabilities and their Caregivers, 1996
Narrative report of findings based on analysis of interviews with individuals with physical disabilities and their caregivers about care experiences.

Interdisciplinary Team Model, 1996
Narrative report describing the planning, initial development, and evolution of the interdisciplinary care team model in the Partnership Program. Includes identification of the complexities involved in providing consumer centered care in an integrated (health and long term) care setting.

Purpose of readings: To gain an understanding of the particular aspects of care and service delivery that providers and consumers consider important when evaluating the quality of care. To understand the similarities and differences among these perspectives.

Introduction:

Part I of this module is based on the belief that in order to work effectively on an interdisciplinary team, each member of the team must first have an awareness of his/her own profession and role within the profession. The exercises that follow will emphasize the importance of each professional having confidence and being competent in his/her work as a professional representing their discipline. The exercises engage participants in a discussion about a typical Partnership member (case study) and intake assessment information. Participants are then asked to identify and prioritize the member's needs, based on their professional expertise. The exercises are designed to allow individuals to reflect on the

professional and biographical experiences they each bring to practice, to interactions with their colleagues and members, and to member assessments in particular.

Instructor Note:
The module is designed to focus on awareness of self (not other) and to
Increase understanding of specific disciplines and individuals as representatives of that discipline. It is important to keep participants focused on their own discipline and role, not on other disciplines. Most participants will need to be directed to focus on their own discipline, as the tendency will be to focus on other disciplines. You must direct participants back to examining the logic of their own practice.

An inability to stay on task may indicate that the participant is experiencing a high level of tension with his/her team or that participant/s lack a good understanding of their own discipline/role.

Teaching Objective:

To explore with workshop participants their understandings of who they are and what they bring personally and professionally to their practice. To encourage an awareness of discipline-specific attitudes, priorities, logic, expertise, attitudes and behaviors concerning common practice.

Desired Outcomes:

- Reflect on themselves as members of a particular discipline;
- Understand discipline-specific orientation that guides their work;
- Gain an awareness of the values, attitudes, logic and priorities of their discipline;
- Identify variation among and within practitioners of same discipline (both in professional perspective, identity, credentials, and influence of personal experiences on professional practice).

Method:
Case Study

1. Participants read:

   Case Study One (page 14) and
   Intake Assessment (page 16)
   Time: 10 minutes.

2. Participants complete

Individual Assessment Worksheet #1 (page 19).
Time: 20-25 minutes

Case Study One

Verna Johnson turned 83 on January 4th. She thought about past birthdays, and how much she had enjoyed celebrating and having her family and friends fuss over her. She loved opening presents. It had been years, she couldn't remember how many, since she had had a real birthday party, or since anyone besides her daughter had thought about it. It didn't really matter. She could just remember the ones from the past and enjoy that. But it also made her sad. The Day Center staff had tried last year. They had a cake and everyone sang 'Happy Birthday,' but she didn't really know those people. They weren't HER people. It didn't feel right. She would rather just remember the good ones. Presents weren't of much use to her any more. What would she enjoy getting? She had everything she really needed and wasn't in good enough shape to do anything other than what had to be done.

Verna worried lately about all the discomforts she was experiencing. No matter what the doctor tried, things just didn't seem to be going very well. It was hard to believe that she could be taking so many pills and not feeling any better at all. In fact, she felt worse now than she did before she started taking the pills. They didn't seem to realize how bad some of this stuff makes you feel. Verna liked to be cooperative and she would never argue with the doctor or nurse. She took the pills, at least sometimes. Usually she took just enough to have the effect they're supposed to, but not so many that she gets to feeling bad. It's a good compromise, she thinks. Everyone is happy. The doctor had told her to be sure to 'say something' if she had problems with the pills. She'd mentioned some of the problems to the nurse who came out last time, but nothing had been changed or even mentioned since.

Verna hated feeling so tired all the time. She also had a few problems with getting to the bathroom on time. She thought this was mostly since her pills were changed, but she wasn't sure. Better not to get too far from home - just in case. It hadn't happened for a while now, but Verna wasn't taking any chances. It seemed to be less likely to happen if she cut way back on liquids. That was easy enough. She really didn't have much of an appetite anyway. She was also concerned about falling again. That was so terrible. What a helpless feeling to suddenly be crashing to the ground…

The nurse was coming out again today to talk to Verna about something. Verna was confused about what she wanted. In fact, she felt a bit anxious. Had she done something wrong? Maybe she wasn't doing what she was supposed to do and that's why the pills weren't working. Would she be able to answer the nurse's questions? The questions some of the nurses asked were often very confusing and Verna realized that she wasn't very good at answering them. She did the best she could, but sometimes it wasn't very good. Some of the people who came to her house were easier to talk to than others, so she told them more. She was sure they would pass on the important information so it wasn't necessary to tell everyone everything. She decided she would concentrate on the things that she had forgotten to tell the other girls. Maybe that's what the nurse wanted to talk about today.

Verna looked forward to the visitor, even if she was anxious. It was something to break up the day. Other than that there was mostly just television, which was OK. She had her

favorite programs, but the TV reception was getting bad. Only 3 channels came in anymore. She also got uncomfortable sitting for very long in her chair. She'd have to get up often to go the bathroom and the up and down was getting more and more difficult lately. She did enjoy watching programs with the girl, Janice, who came to help her each day. She had become a real friend, a good friend. Janice was willing to help Verna with things and didn't tell the doctor when Verna decided not to take all of her pills. She was a good friend. Verna did little things for Janice to show her how much she was appreciated. She occasionally gave her the day off, making it their little secret. Janice sometimes needed time to take her little daughter to the doctor or take care of some of her own business. Janice always made up for it in other ways, like bringing treats that Verna really liked. And if Verna ever needed anything, Janice was always willing to help. Sometimes she even came over with her daughter on her day off. Verna kept a drawing from Janice's daughter on her refrigerator. She was really special.

Janice was really good with advice too. She had cared for her aunt and her mother when they were ill and she knew all about this kind of work. She had some wonderful home remedies and she was also great at massage. Besides that, Janice knew what was important to Verna without even asking.

INTAKE ASSESSMENT

Name: Verna Johnson
Date: 1/7/1998
DOB: 1/4/1915 Age: 83 Female

PRECIPITATING FACTORS:

Ms. Johnson was referred to the ElderCare Partnership Program on Nov. 18th, 1997 by the South Madison Coalition for the Elderly. This referral was made due to the following concerns: (1) ↑ fatigue (2) ↑ isolation (3) H/O urinary tract infections (4) inconsistent medication compliance (5) non-insulant dependent diabetes (6) recently had 2 falls in her home (no apparent injury) and (7) congestive heart failure

FAMILY AND MARITAL HISTORY:

Ms. Johnson was born on January 4, 1915 in Cross Plains, WI. She was the youngest of three children. Her two sisters are now deceased – both lived well into their 80's. Ms. Johnson's father worked very hard on the family dairy farm. Her mother raised the children, worked in the home, and took in laundry from neighbors and friends to help with the family budget. Verna describes her childhood as "normal" and she states "we were very poor but we never knew it – everyone we knew was poor...that was life." Verna remembers her father as task oriented and " a man of few words." Her mother, Verna recalls, was a very hard worker but very fun loving. Attending school was a real joy for Verna. She attended school through the 12th grade and did very well academically. Verna furthered her education by attending Normal College where she earned a teaching certificate. Teaching grade school was "a wonderful time in my life." She taught school for eight years (1935-1943). In 1942, Verna met her husband to be, John, at a church picnic. "It was love at first sight for both of us." On July 3, 1943, Verna and John were married in Cross Plains, WI. They set up home making in Cross Plains, approximately two miles from Verna's family home/farm. One child, Linda, (currently in Minneapolis, MN) was born of this union. Verna described her family as very close. She loved raising her daughter and keeping up with homemaking tasks. In addition, Verna kept active in her daughter's school by volunteering on the PTA and with tutoring. Verna's husband worked in nearby Madison as a automobile salesman. As a family they were very active in their church. Verna describes herself as very spiritual. She has many friends with whom she socialized and gave/received support whenever needed. In 1981, Verna's husband suffered a stroke which left him paralyzed on the left side of his body. Verna provided all physical cares as well as emotional support for her husband. On July 3, 1983, John dies at home on their 40th wedding anniversary. Soon after John's death, Verna's daughter and son-in-law moved from Madison

to Minneapolis, MN. Verna laments that in addition to these losses, many of her friends were becoming more frail and either moving closer to their children or dying.

LIVING SITUATION/CURRENT SUPPORTS:

Verna's support systems are "dwindling." However, she continues to live alone in her own home and is proud of her independence. At times, Verna conceded, keeping up with her home it "too much for me to handle." Verna has telephone contact with her daughter at least 2x per week. She has one close friend/confidant, Janice. Janice works for a local home health agency. She is assigned to assist Verna 2x week (2 hrs. each visit). She assists with setting up medications, personal cares, meal preparation and occasionally with her heavy household chores as needed. In addition, Verna attends an Adult Day Center 1 day/week.

PHYSCIATRIC HISTORY:

No HX of psychotic problems, however Verna's daughter Linda has recently expressed concern that Verna seems sad and she questions if Verna is depressed. Verna admits to feeling lonely and sad but she states "I'm not crazy or depressed – just sad sometimes."

PREFERENCES/DESIRES:

Verna states with conviction that "I want to stay in my own home until I die." She states concern about not getting out of the house much due to problems with bladder incontinence periodically. Verna laments that she doesn't get out of the house except for going to a local day center on Wednesday's from 9-2. Verna states she may like attending the center one more day/week but further states that she cannot afford to pay for the additional days at the center.

FINANCIAL INFORMATION:

Verna receives approximately $700/month in social security. Excluding her home, Verna's only assets are $1800 in a savings account and a burial trust fund in the amount of $1250. Verna has Medicare Part A and B. Verna describes her finances to be very tight.

GENERAL HEALTH:
(What do you identify as your biggest concern?)
(How much alcohol do you drink weekly?)

Verna reports that she "hates going to see her doctor." She feels rushed whenever she goes into the clinic. Verna has a dx of NIDDM, recurrent UTI's, and CHF. Verna's biggest concerns are (1) "I think my medications are making me worse." (2) I've started falling lately – I'm afraid I'll break my hip" and (3) "I am embarrassed that I wet myself sometimes"

COPING SKILLS:

"I pray a lot…that gets me through my problems. I also love my stories on TV, but my TV is very fuzzy – sometimes I can't get a picture tuned in at all. I also love to talk to my daughter."

CHURCH/SPIRITUAL INVOLVEMENT:

Verna is of the Lutheran faith. She only attends church on special holidays due to concerns of incontinence. About 2 years ago, the assistant minister visited Verna in her home each week. But since he left the church and moved to Chicago, no one visits Verna from the church. She doesn't want to "bother" anyone.

ADVANCED DIRECTIVE:

No POA for HC has been completed

PHYSCOSOCIAL FUNCTIONS, MOOD, APPEARANCE AND COGNITION

Verna takes great pride in her appearance and is always really well dressed and well groomed. She is alert and oriented x3. However, she has periods of confusion (probably due to UTI's). Verna describes her mood to be generally 'OK", but as stated above, her daughter is concerned that Verna may be increasingly more depressed. This writer is concerned regarding Verna's increasing periods of isolation. She reports to have only a few people with whom she feels comfortable.

Team Member Professional Identification
Part I: Professional Self Knowledge

Individual Assessment Worksheet #1

After you have read the case study narrative and reviewed the completed assessment forms, please answer the questions below. During the group discussion about this exercise, please make note of areas (circle) where your answers varied from other professionals in the group:

1. Think about the consumer's most pressing concerns. Develop a problem or issues list, prioritizing the strategies, interventions, and services that the member needs. Please list them in the order of urgency or importance:

Instructor Note:
Be sure to briefly summarize the purpose of this exercise for the workshop participants. It is intended to explore whether/how a discipline's approach to practice is consistent with their responses to the case study. The instructor should be listening for inconsistencies and noting what seems to account for these.

2. A._____

   B_____

   C._____

Instructor Note:
Team members may come up with more than three items for #1 <u>but</u> encourage them to prioritize what to to do first, and then ask them to explain why those things are the most important to address first.

2. Can you think of anything you don't know, but would need to know, about this member?

3. <u>Why</u> do you need to know these things?

4a. How do you determine the goals for this member?

4b. Based on what you know, what are the goals for this member?

4c. For each of the items (above, #1.A-C), what is the member's role or responsibility?

5. Determine whose (NP, RN, SW, PCW, member, family, other) responsibility it is to organize, carry out and evaluate the interventions for the consumer needs (in #1 above)

1.A (above):
Who organizes? _____

Who carries out? _____

Who evaluates? _____

1.B:
Who organizes? _____

Who carries out? _____

Who evaluates? _____

1.C:
Who organizes? _____

Who carries out? _____

Who evaluates? _____

6. Identify criteria that should be used for each of the identified needs/goals to evaluate the effectiveness of the care:

1.A:

1. B:

1. C:

Method: Guided Large Discussion (1-5 below)
Option: You may conduct this exercise individually or as a group. *Time:* 40 minutes.

Instructor to participants:

1. Look at #1 on the worksheet where you have identified and prioritized the consumer's needs. How did you decide on what the member needed? What are the assumptions (about the population, the urgency of the situation, what's most troubling to the consumer, past experiences, your ideology about care, the job…) guiding your identification of the member's needs? What are you bringing to the situation that's not coming from the consumer? Is there anything being assumed here?

Instructor Note: Introduce 'advocacy' here **if** participants do not spontaneously mention – what can happen when single person of discipline OR more than one person of same discipline identify as the consumer's advocate

2. How did you the prioritize needs in #1 (on the worksheet)? How did you decide that any one need was more important than any other? Tell me the logic behind your thinking…. What information, assumptions, knowledge did you base your decisions on?

Instructor Note: If there are differences in the thinking between practitioners – Identify these for the group and examine them. If they are all thinking alike, what logic guides all of them?

3. If you accomplish your goals for this consumer, what are the consequences for the consumer? For the consumer's family/caregiver? For the organization? For you?

4. How did you select the criteria for evaluation (#6 on worksheet)? What do each of these criteria tell you? What don't they tell you? Does the criteria you selected correspond to the responsibilities you assigned in question #5 on the worksheet?

5. Think about your own personal history and your professional experiences…how might these things influence your approach to this particular case study?

Optional Discussion Topics

1. Identify something (way of doing something, process, task, etc..) from a previous job, that you thought was really great, but that doesn't seem to be working in your job now.

1. Is your personal approach in any way inconsistent with a common discipline approach? For example, comparisons between you and your colleagues (without identifying individuals).

Part II:
Sharing Self-Knowledge

Introduction:

Part II of this module is designed to allow participants to explore what it is about their perspective that is common to and different from other professionals *in their own discipline*. The following discussion should help participants to understand how personal and professional experiences influence professional practice. It should help each participant identify – as a group – the boundaries of their own discipline's practice. This exercise should also serve to reinforce workshop participant's beliefs about the unique contributions the discipline makes.

Teaching Objective:

To sum up self-knowledge and share this knowledge across single discipline professionals.

Instructor Note: It is important to distinguish which questions below are appropriate for the group. This will depend in part on the comfort level the group established in Part I of this module. It is also important to be aware of and recognize how the care setting in which participants may have practiced prior to working in the WPP model (nursing home, home health, hospital, etc..) effect their current practice.

Audience: Same as Part I.

Desired Outcome:

Each participant's knowledge and understanding about their professional discipline should be enhanced.

Method:

Guided Large Group Discussion: Reflect on the Individual Assessment Worksheet you completed in **Part I** during this discussion

Discussion Questions

What was it like to be involved in this process of reflection?

What did you learn/confirm about yourself and your colleagues?

What questions, if any, did this raise about you/your discipline approach assessments?

What is unique about how your discipline assesses and prioritizes members' needs? What difference does this make?

What is most significant about what your discipline contributes?

Think about your professional and personal experiences... How do these experiences influence the way you think about care?

Were the decisions that you made different from what your colleagues identified?

Take a look at the case study/assessments. In order to provide the best quality care, what is needed beyond what you, or your discipline, have to offer?

* * * *

"Homework Assignment" for Day 2: Instructor: Please ask participants to come to Day 2 prepared to discuss the following…

#1: Think about an experience you've had at work where something about your philosophy or approach to a situation did not mesh well with how the situation was ultimately managed...

#2: Think about a situation you are really proud of that demonstrates what your professional work is all about...

Instructor Note: Day 2 of the workshop will open with an opportunity for participants to reflect on Day 1, and to discuss the "homework". The intent of the homework is to provide another opportunity for team members to make their discipline/approach to practice 'visible' – being explicit about what the approach requires of them and how it is similar/different to practice approaches used by other members on the team.

End Day I

Day Two

A. Reflect on Day 1

Method: Large Group Discussion: (10 minutes)

1. What was it like to be involved in Day One in a process of reflection about your discipline?

2. What did you confirm about yourself? Your colleagues?

3. Was there anything that you were surprised about?

B. Discuss Homework assignment (if assigned)

Method: Large Group Discussion: (10 minutes)

Question #1: Think about an experience you've had at work where something about your philosophy or approach to a situation did not mesh well with how the situation was ultimately managed ...

Question #2: Think about a situation you are really proud of that demonstrates what your professional work is all about...

Part III.

Cross Discipline Awareness

Introduction:
This part of the module assumes that participants have a good understanding of their discipline and some understanding of how personal experiences influence the way they approach care. Building on that, Part III is designed to shift the focus to the other discipline. Participants will use completed exercises from Part I in this section.

Instructor Note: Part III of this Module is very different from Module II. Module III focuses on the *integration* of the disciplines rather than on a mutual understanding *between* the disciplines. Module III can only be successful if there is a mutual respect and appreciation by participants for all disciplines on the team. Building this foundation is the goal of the activities below.

Teaching Objective:
To encourage each discipline to appreciate the expertise and contributions that are unique to both disciplines. To dispel the notion that any single discipline is more important or has more authority than the other. To increase understanding of how each discipline can contribute to a single situation. Each discipline will learn about the values, attitudes, logic, service priorities, and, consequently, differences in assessment of the other discipline. The accomplishment of these goals is a prerequisite for providing integrated, high quality, consumer centered care.

Instructor Note: If a workshop group seems to have a high level of conflict, and/or a low level of trust, then the disciplines should probably be kept separate during this part of the module. You might also consider having a competent professional expert from the other discipline included in the discussion. In such cases, it might be helpful to complete the exercise first as a single discipline and then later revisit the activity as a mixed discipline group.

Desired Outcomes:
To increase knowledge, understanding, appreciation for, and respect for the other discipline and for colleagues as representatives of that discipline.

Introduction to Group:
Day 2 is structured to begin to explore with you your understandings about other disciplines on the IDT. We will begin with social work and then participate in an activity that will incorporate other disciplines (PCW, doc) as well as program members and family caregiver perspectives.

Method 1: Large Group Discussion Questions (30 minutes)

Instructor to Group:
What does the social worker/social services coordinator do?

What is the purpose of having the social services coordinator (SSC) on the team?

Instructor to Nursing Staff:
What does the SSC do that makes your job as a nurse easier? What do you do as a nurse that helps them?

Instructor to Social Services Staff
What do the nurses do that makes your job as a SW/SSC easier? What do you do as a SW/SSC that helps them?

Instructor to Group:
What is the SSC role and the nurse's role in terms of Member QOL?

We've heard a lot about the importance of being able to establish "trust" with the member (consumer)….Do nurses and social workers/SSC each establish "trust" with the member differently?

Method 2: Group Activity

1. Each workshop participant has to choose one of the following roles to play:

RN NP SW PCW MD

Optional: Member, Family member

2. Complete **Group Assessment Worksheet #2** (page 27) ***from the perspective of the discipline/role you have been assigned.*** **(20-25 minutes)**

Break (10 minutes)

2. Ask each participant to share with the group what they identified as on their worksheet based on the role (discipline) they represent (**display varying perspectives on board…) – 40 minutes**

Workshop Evaluation: It is suggested that the instructor design and administer an evaluation based on the specific objectives identified with management staff prior to conducting the workshop.

Team Member Professional Identification
Part III: Cross-Discipline Awareness

Group Assessment Worksheet #2

Reflect back to the case study narrative and the completed intake assessment forms from Day 1. Please answer the questions below ***but now do so from the perspective of the discipline/individual that you represent during this exercise (i.e., RN, SW, NP..).***

1. Think about the consumer's most pressing concerns. Develop a problem list, prioritizing the strategies, interventions, and services that the member needs. Please list them in the order of urgency or importance:

A._____

B_____

C._____

2. What other information would you need to know, *as the discipline/role you represent today*, about this member?

3. Why would you need to know these things?

4. Discuss the logic of your decisions (above)?

5. For the first item (in Question #1: A), what would you expect of the member and what would be your role?

Member role:

Your role:

6. How will you evaluate the effectiveness of <u>your</u> care? What will tell you that you are providing high quality care regarding the needs you identified in Question #1 (A)?

END MODULE I

Curriculum Outline*

Module II: Providing High Quality, Consumer centered Care

Day One

- Consumer Centered Practice: Provider Perspectives

Day Two

- Consumer Centered Care: Consumer Perspectives

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[Note**: Module II is currently formatted as a 2 day workshop]*

Day One

Part I.
Consumer Centered Practice: Provider's Perspectives

Instructor Note: The following Partnership Quality Research reports, developed by the Partnership research team, should be read by the instructor prior to conducting this Module:

Quality Care from the Perspective of Elderly Consumers, 1996
Narrative report of findings based on analysis of interviews with elderly consumers about their care experiences.

Quality Care from the Perspective of Consumers with Physical Disabilities and their Caregivers, 1996
Narrative report of findings based on analysis of interviews with individuals with physical disabilities and their caregivers about health and long term care experiences.

Interdisciplinary Team Model, 1996
Narrative report describing the planning, initial development, and evolution of the interdisciplinary care team model in the Partnership Program. Identification of the complexities involved in providing consumer centered care in an integrated (health and long term) care setting are included.

Purpose of readings: To gain an understanding of the particular aspects of care and service delivery that providers and program members consider important when evaluating the quality of care. To understand how perspectives on high quality care can differ between providers and program members. A thorough reading should assist the workshop instructor to identify when a participant in the workshop is:
1. describing something from the perspective of a member (consumer),
2. describing what he/she thinks is important to/for a member, or
3. when a workshop participant's own perspective actually replaces that of a member.

Background:
Many health and long term care providers believe that the provision of care and services should be responsive to the person receiving services. This is reflected in a variety of terminology used by providers to described client/patient-focused care, client/patient-directed care, client/patient-centered care, client/patient-responsive care, etc.. Despite similarities in the terminology, beliefs about how to provide such care tend to vary widely across settings and disciplines. There are important conceptual, practical, and ideological variations across disciplines about how to assess, implement, and evaluate care in a way that is responsive to the member. **Note:**

Although the exercises in this module will introduce and explore some of those variations, the term consumer centered care will be used for the sake of consistency.

Different understandings about consumer centered care among team members can make collaboration difficult since team members are often working towards different goals. In addition, even when there are shared understandings about the meaning of consumer centered care, there are practical challenges to actually delivering consumer centered care. Significant variations in defining and implementing consumer centered care become visible when providers representing different disciplines collaborate on how the member's perspective will be integrated into the plan of care and how care and service priorities will be determined.

Important aspects of integrated care that seem to raise the most questions include:

- The meaning of **Advocacy:**
  - -who is qualified to be a consumer advocate?
  - -can more than one team member be a consumer advocate?
  - -what is an advocate advocating for?
  - -what expertise do you need to be an advocate?
  - -what assumptions are built into the belief that a single advocate is needed?

- The role of **Professional Expertise:**
  - -what is the nature and range of expertise required to provide high quality, consumer centered care? how is this expertise gained?
  - -what are the credentials needed for being an 'expert'?
  - -how are experts held accountable for providing expertise/expert care?
  - -can members be 'experts'?
  - -when does expertise interfere with providing consumer centered care?

- Assessment of **Risk/Accountability:**
  - -what "risks" are being referred to when the phrase "dignity of risk" is used?
  - -how informed should a provider/member be about the nature of the risk?
  - -what expertise and perspective do you need to have to minimize risk?
  - -when, and for what, is the provider/member accountable?
  - -how do professional standards of practice get addressed in terms of accountability?
  - -who is the provider/member accountable to?
  - -how should risk influence decisionmaking about what's possible?
  - -what is the member's role in risk determination?

- Personal/professional **Boundaries:**
  - -what are the boundaries between the member and team members?
  - -how are the boundaries determined? Do they vary by profession?

-how are concepts of professional boundaries developed? where do they come from? (professional training, personal values..)
-when/can they be altered? who gets to determine this?
-who's accountable in relation to boundaries?

- Tension between **Obligations** to the organization, to colleagues, to the profession, and/or to members:
  -what are the provider's obligations to the organization, to colleagues, to professional discipline, to self and/or to members?
  -how does the provider determine which of these obligations takes preference when there is conflict between/among them?
  -how do these obligations relate to Advocacy, Professional Expertise, Risk/Accountability, and Boundaries?

In Module I, workshop participants explored many of these issues during discussions about how each discipline assumes a different perspective, knowledge, and skills when assessing member needs and developing a plan of care. Discipline specific education and training, as well as personal and professional experiences, lead to predictable variations in member assessments and care planning.

Building on Module I, Module II will explore variations among providers about the nature of consumer centered care. This will be accomplished by exploring what consumer centered care means to team members, providers, and members. Module II consists of 2 parts:

Part I: Consumer centered Practice: Provider Perspectives

Part II: Consumer centered Care: Consumer Perspectives

Instructor Note:
As part of their professional education, both social workers and nurses see themselves as patient/consumer advocates, and often see themselves as the best consumer advocate as opposed to someone else. For example, in systems where access to services is limited or restricted, and when consumer preference is not central to decisionmaking, social workers often become the primary consumer advocate, facilitating consumer access to services and maximizing the 'consumer's voice'. On the other hand, nurses often find themselves advocating for patient self determination primarily in acute care settings. In addition, they sometimes find themselves advocating for access to resources needed to maintain health in other (community) settings. It is important to understand that when each discipline refers to being an advocate, they often refer to advocating around different issues.

When providers work together on an integrated team that includes the member, these different types of advocacy must come together. Integrated practice includes being inclusive of all types of advocacy and having respect for what other team members advocate for. This requires team members to understand their own as well, as other team members' roles in advocating for the member. Designating a single individual, or discipline, as "the advocate" can undermine the

inclusion of these different approaches to care and the interdisciplinary decisionmaking process. Conflict between team members is created when 'the advocate' becomes an 'outsider' to the team, and fundamentally at odds with a collaborative team concept. Having a single advocate can also reinforce the notion that other providers don't have to see themselves as consumer advocates. Module II is intended to explore how each team member can be an advocate for the member.

Based on the Partnership research, this curriculum assumes that the best use of the social worker tends to shift from being 'the' advocate to helping the team identify incompatibilities or differences between the member's perspective (specifically, maintaining a particular quality of life and/or preferences about how services are organized and delivered) on the one hand, and maintaining standards of practice on the other. Tensions can arise when health care providers become too focused on health care issues (medical model) and/or health care providers have difficulty integrating the care and services that they provide with member preferences or choices.

Assumptions that either discipline is not consumer centered, or has more authority to represent the member's perspective, will be made visible and addressed directly during workshop session discussions. Workshop facilitators should lead discussions *away from* whether a discipline is more or less consumer centered, *toward* discussions about the different understandings each discipline has of consumer centered practice, how each professional makes important contributions to consumer centered care, and how each team member can be an advocate for those issues that fall into their professional area of expertise.

Teaching Objectives:

- To increase each discipline's understanding of what consumer centered practice can look like *from each discipline's perspective,*

- To increase appreciation for the other discipline's perspective, and to understand the limits of their own perspective as consumer advocate

- To understand the potential benefit for the member when multiple perspectives are integrated, instead of separated, during team decisionmaking.

Workshop participants should also gain an awareness of how they can relate to, and include, the member in decisionmaking, and how collaboration between the disciplines (interdisciplinary team) differs from practicing either alone or in parallel with one another (multidisciplinary team). These exercises will also provide an initial examination of the assumptions each discipline has about the nature of the relationship between providers and the members they work with, e.g., professional boundary issues and professional expertise. Participants must also understand the relationship between quality care based on standards of practice and quality care that includes responsiveness to a particular

member (views the issue from the member perspective). Most importantly, participants must be able to integrate these two approaches when providing care.

Audience:

It is recommended that this module be conducted with mixed discipline groups, preferably with one or two whole teams. This is an opportunity for mixed discipline groups to examine, in-depth, the logic and assumptions of each discipline's understanding of consumer centered practice, and to explore the similarities and differences among their practice approaches. It will illuminate what each team member contributes to the team and what difference these contributions make towards developing a consumer centered plan of care.

Desired Outcomes:

At the end of Part I, workshop participants should have a clear understanding of the different ways in which their disciplines define, approach, implement, and evaluate consumer centered practice. Participants should also gain an awareness of how consumer centered practice may be similar and/or different among practitioners of the same and different disciplines.

Method: Individual Activity and Group Discussion

Instructor Note: As participants arrive, each should be provided with Handout #1 (Appendix 1) which directs them to each write a brief description of: 1) a time they provided consumer centered care, OR 2) a description of practice (theirs or someone else's) that clearly was NOT consumer centered. Ask participants to put this example aside until later in the workshop. During your introductory comments, explain that although team members may have experience practicing on an interdisciplinary team, even be familiar with what each professional discipline on the team contributes to integrated practice, that the purpose of today's exercises, and the exercises on Day 2, are to examine ways in which the skills and expertise that each team members brings to the team can be effectively integrated to provide high quality, consumer centered care.

Stress that participants should leave this workshop with an enhanced understanding about how their contributions can be integrated with the other members on their team, not just added to them, for the benefit of the program members they work with. They should also better understand some of the ways in which members can become more effective participants in their own care.

Instructor Directions:

1. Distribute copies of the discipline specific member assessments **(Appendix A)** to participants of corresponding disciplines (i.e., nursing assessments to nurses; social

work assessments to social workers/social services coordinators). Explain to participants that they are receiving discipline specific assessments based on the same member (Rob) and ask them to review the assessments.

2. Ask nursing professionals in the group to respond to the following questions (a. - f. below) based on the information in the assessment that has been provided to them. During this time, social work staff should be directed to listen to the nurses and consider the question: Why do the nurses need the SW's input? Specifically, they should be directed to a) identify information they have in their SW assessment that relates to something the nurses are discussing – what information do you have that you think would be important for them to have? and why?? and b), what do you hear the nurses saying that would raise questions for you - things that they don't seem to be asking? Next, social work professional should be asked to respond to the same questions (a-f), using only the information provided to them on the SW assessment, while nursing staff listen:

Instructor Note: Record participant's responses on a chalkboard (see outline on next page) where everyone can see them. Highlight how each discipline would approach each question (a.-f.) similarly or differently. **(each discipline should have 15- 20 min to respond to a.-f.)**

a. What are your (as a discipline) most important goals for Rob? Pick 1 or 2.

b. Is there any additional information you need about Rob in order to develop goals for him? If so, what is that? And where would you get that information?

c. Are there any issues reflected in the assessment you have that you would consult with the other discipline (nurse/social worker) about and why?

d. Is there anything in the assessment that you think is purely in the domain of your discipline (something you don't need to consult with your team members about)? Discuss this with the group.

e. Is there anything in the assessment that you think is purely in the domain of the other discipline (something that the other discipline doesn't need to consult with you about?) Discuss these responses with the group

f. Is there anything in the assessment that you must consult with your entire team about?

ON CHALKBOARD:

	(Column 1) *Nursing Professionals…*	*(Column 2)* *Social Work Professionals…*
a. Goals:	1.	1.
	2.	2.

b. Information Still Needed:

Source of Information:

c. Collaboration…:

d. Purely my domain:

e. Purely their domain:

f. Consult with team about:

Instructor Note: If team members spontaneously mention **efforts to educate Rob, or the need for "making sure Rob is "informed"** as part of their plan of care, make sure to ask them the following**:**

What outcome are you trying to achieve?
What information will you share with Rob when you educate him?
Why will you present this information to Rob?
Is there anything you leave out? Why leave it out?
What do you anticipate will happen after you have shared information with Rob?
How do you think providing this information to Rob will help you achieve the outcome identified above?

Purpose of this discussion is to identify how consumer education is used: is it used to inform the member or to persuade or coerce the member to make a decision that agrees with the provider's preferences? What difference does this make in terms of consumer centered care (what are the limits and how do you determine these)?

BREAK – 10 MINUTES

REST OF DAY ONE IS SPENT ON THE FOLLOWING DISCUSSION:

3. After both nursing and social work professionals have responded to a. – f. ask individuals in the group to comment on what has been presented:

   Ask: In particular, what do you think about what one discipline has identified in terms of what is needed from the other, either for purposes of assessing Rob or developing and implementing a plan for Rob?

   Ask: Does anyone think the original goals that were designated for Rob (responses to question a.; Columns 1 and 2) should change, or be altered in any way, now after you've heard from both disciplines about how they've assessed and approached Rob's situation? Did you hear from another team member anything that made you think of a new or different goal, a different way to assess the situation, a different plan for Rob - anything?

Instructor: On the chalkboard, add a third column (after 'Social Work Professional') labeled 'Integrated Goals' and document participant's responses to the above question. DO NOT SKIP THIS STEP – participant's responses will reflect their ability to expand their perspectives to include integrated goals.

5. Look at the integrated goals you've come up with: how is what is important to Rob reflected in these goals?**** Was Rob asked directly about these issues? What does consumer centered care mean? In what ways is the integrated care plan more consumer centered that either of the individual plans? Is it more consumer centered? How?

**** Instructor Note: Appendix E** has specific follow-up questions you can pose to team members while they discuss 'Integrated' goals/care above. The follow-up questions in Appendix E are grouped under specific assessment areas from the discipline specific assessments that participants were given. For example, if team members focus on or discuss Rob's vision (maculardegeneration), refer to Appendix E under the heading "Vision" to determine whether the team is approaching the issue of Rob's vision in a way that considers the impact an intervention might have in Rob's life.

Purpose of discussion here is to stress the need for high quality clinical practice *that integrates the member's perspective.* As team members collaborate to manage a member's condition, how do they do so in a way that maintains or enhances the member's quality of life?

6. **Instructor to group:** Once we're in agreement that our integrated care goals are consumer centered, let's develop a brief plan of care for Rob– what are the first three things you would address in a three month plan of care for Rob? (Write these on the chalkboard)

Ask: Could you have actually developed this plan of care without ever meeting Rob? What is it about knowing the Rob that affects or directs this plan of care?

Ask: What keeps you from actually implementing this plan? Is there anything that gets in the way of moving forward with an integrated plan?

Ask: What are some practical strategies for maintaining integrated, consumer centered practice?

-Assessments – how/can these be done differently?
-Team Meetings – what needs to be in place
-Implementation – what needs to be done to make plan work?
-Visits to Members homes - who does what and how often?
-Documentation – what gets documented and why?
-Outcomes/Evaluation – what tells you if you've been successful or not?

Instructor to group:
We've completed the exercises for today….is there any general feedback you would like to share about today's experience?
I have a brief "homework assignment" for you to think about for next time (confirm date/time of Day II with group):

"Homework Assignment"

Ask participants to review the example of consumer centered care that they wrote about at the start of this session (Appendix 1). Ask them to reflect on today's exercises and think about the following**…..**

1. Given what we did today, how does my example of consumer centered care match with the things we talked about today?
2. When I reflect on your example, what else, ideally, should be there (Is there anything missing from this example)?

Participants should be prepared to talk about this at the start of Day 2.

END DAY 1

DAY II

Part II.
Consumer centered Care: Consumer Perspectives

Introduction: In general, health care providers tend to rely on clinical process or outcome measures to determine the quality of care. In contrast, social workers attempt to rely on their success in achieving consumer reported preferences when evaluating the quality of care. Consumers tend to assume that both clinical outcomes and personal preferences should be integrated into care provision. Therefore both provider perspectives are required to deliver what the consumer perceives to be quality care.

Teaching Objectives: To assist participants to:

- Understand commonalties in how consumers (in general and specific populations: frail elderly, chronically ill, and persons with physical disabilities) perceive quality care, and how this may be similar to or different from providers perceptions;
- To become aware of the factors that influence how consumers evaluate the quality of care; and
- To assist providers to identify and integrate consumer preferences and perspectives into their practice.

Audience: Same as Part I.

Desired Outcomes: Participants should be aware of the similarities and differences between consumer and provider perspectives about quality care and consumer centered care. Participants should be aware of how the process of service delivery can affect both member evaluations of quality and member quality of life. Participants should be able to identify strategies to obtain member perspectives about care and to integrate this information into the planning, delivery and evaluation of services.

Method: Reflect on Day 1/Homework:

Would anyone like to share their thoughts on Day 1, or about the homework assignment?

Ask: Take a look at the example you wrote about at the start of Day 1. Does this look any different to you now? If not…?

Instructor Note: Brief Introduction about Focus of Day 2 Activities

Method: Case Study

1. Provide participants with the Edith (E) (Appendix B). This case study presents differing perspectives about what a team's goals should be for a particular member.

2. After reviewing the case study (5-8 min), instructor should ask participants to respond to the following questions:

   a. What would your goals for Edith/Joe be? What would you include in a plan for Edith? Instructor: Make sure participants are explicit about why they pick the goals they do – Ask participants to share their evidence for focusing on particular goals

   b. If you don't have enough information to decide what to do or to formulate goals, what other information do you need?

   c. Why do you need this information (what is purpose of the information; what will it help you to decide?), and

   d. Where would you obtain this information from?

ON CHALKBOARD, RECORD:

a. Goals: 1.
2.
b. Information
Still Needed:

c. Purpose of
Information:

d. Where would you get this information:

3. **Instructor:** Reflect on the information that's been provided by participants….Has anyone identified needing Edith's perspective? If so, how would they obtain Edith's view? Ask: Is there a decision you don't really need Edith's perspective to make? If not, discuss why not with the group…If yes, discuss how knowing Edith's perspective might change things (what do you want to know?). Also ask team members to specifically identify how they will get that information, i.e., what questions will they ask?

Instructor Note: When/Does the group identify needing to educate Edith or Joe or provide them with information? Each time the team suggests consumer education or suggests providing

information to the consumer, is the action based on knowing enough about Edith/Joe? Understanding enough about what Edith/Joe want from the program? For example, do they know enough about what Edith/Joe is afraid of/concerned about to appropriately select information to provide to her/him?

Purpose of this discussion is to identify how consumer education is used: is it used to inform the consumer? Is it used to persuade or coerce the consumer to make a decision that agrees with the provider's preferences? What difference does this make in terms of consumer centered care?

4. Has anyone identified needing Lily's (the personal care worker) perspective on the situation? If not, discuss why not… If yes, discuss how knowing Lily's perspective might change the goals identified. Also discuss team members to specifically identify how they will obtain that information (from the PCW):
   - who will they talk to?
   - what questions will they ask?

BREAK – 10 MINUTES

Instructor: Provide the group with the Joe and Lily's on the situation they are working on. (Appendix C) Ask workshop participants to review this.

Ask: Does knowing these perspectives influence the responses you provided to a. - d. (above)? How?

Discuss: This information (from Joe/Lily) is often very important information that you may not have access to… What are some strategies to build into practice that would increase the chances that you would be more likely to get this information? Specifically, how do you include family members and personal care workers in decisionmaking and information sharing?

Ask: What would you do in a situation if the member couldn't communicate with you?

5. Next, have participants review **Appendix D**. These are the sorts of questions and issues that Partnership members identify considering when they evaluate the quality of care they have received.

   As you can see, chronically ill individuals and individuals with physical disabilities often evaluate the quality of care/services *based on aspects of the care experience that may be different from those that providers might consider when they evaluating quality.* Both perspectives are important to consider when providing high quality, consumer centered care.

6. Let's pick a couple of the items in Appendix D to focus on and discuss how the consumer centered plan each of you developed in #3 (above) addresses these particular member concerns.

7. As a final exercise, let's try to develop a definition of collaborative, consumer centered care based on what we've done here today. Is there a way to write this definition that includes the goals that each discipline thinks are important and that includes the member's perspective? (Display the definition where everyone can view it.)

Workshop Evaluation: It is suggested that the instructor design and administer an evaluation based on the specific objectives identified with management staff prior to conducting the workshop.

End Day Two

Appendix 1

HANDOUT #1

***Question**: "Client-, patient-, or consumer centered care" is a term we often hear used by health and long term care professionals. Would you please briefly write (below) about a time you provided client centered or consumer centered care? Or you may write about a time when you or someone you worked clearly did not provide consumer centered care – this could be a time during your work with Partnership or in another setting. Provide as much detail as you can in 5 minutes (you won't be sharing this with the group. It's for your own use). Thank you.*

Appendix A

Nursing Assessment – October, 1998
Member: Robert Jones

MEDICAL HISTORY

PRIMARY MD: Dr. Smith
OPTHALMOLOGIST – Dr. Glow
DENTIST – Dr. White
ENT – Dr. What

ALLERGIES: Codeine and Penicillin

CODE STATUS: HCPOA established

DIAGNOSIS/CHRONIC PROBLEMS:

Tobacco use; 1 pack a day x 40 years. Quit approx. 23 years ago
History of Falls (unsteady gait)
Compound fractures from fall – pain when standing/walking
-shoots down L leg/hamstring
Maculardegeneration (extremely poor vision; nearly blind)
Depression
Parkinson's (tremors – both hands, left hand greater than right)
Hard of Hearing; right hearing aid
Constipation: history of last several years; no treatment
Occasional musculoskeletal pain

RECENT HOSPITALIZATIONS: Cholecystectomy

DIABETES – No history

LIST MEDICATIONS
Naprosyn for back pain
Relafen script – 500 mg QD
Colace – 100mg PO
Zoloft – 50 mg PO QD
L-dopa – 25/100 TID

Nursing Assessment – October, 1998
Member: Robert Jones

IADL's

- **LIVES WITH:** alone; grandson nearby and over often
- **HOUSEKEEPING:** needs assistance with
- **LAUNDRY:** needs assistance with
- **MEALS:**

-Diet: needs assistance with prep

-MOW:

- **SHOPPING:**
- **TRANSPORTATION:**
- **SOCIAL:**
- **FINANCES:**
- **EXERCISE**: Before fall Rob walked once a day either outside or at the mall

ADL's

- **BATHING**

EQUIPMENT-SHOWER CHAIR/BENCH: bench installed; fears showers
HANDHELD SHOWER: installed
RAISED TOILET SEAT:
GRAB BARS: installed; hand rails on stairs too
COMMODE:

- **DRESSING**

EQUIPMENT
TEDS

ADL's per self and grandson; some daily assistance is ordered

FAMILY HISTORY: Mother died at age 68; unknown causes. Father also deceased of unknown causes. One brother alive and well.

SOCIAL HISTORY: Participant was born on a farm in Green Bay, WI. His mother died when he was 8. Rob states he cared for younger brother from age 14 on. He has completed high school. He has worked in numerous jobs including accounting and sales. His wife died in 1987 of cancer. They were married for 54 years. His second wife died earlier this year. They were married for almost 8 years.

Nursing Assessment – October, 1998
Member: Robert Jones

REVIEW OF SYSTEMS:

GENERAL: states health is "pretty good", "I'd like to get on my own completely.."
WEIGHT LOSS: reports that usual weight is 190#; currently at 150
APPETITE: reports he has a good appetite; currently getting meals on wheels at lunch. No snacking reported.
METABOLIC/ENDOCRINE: denies night sweats, hair loss or heat/cold intolerance
SKIN: denies any problem
HEAD: denies headaches; reports dizzy when laying in bed over last 4 months. Denies syncope or tinnitus. Currently sleeps in rocker.
EYES: sees shadows; history of maculardegeneration
EARS: hearing aid (right). Reports hearing is worse lately, especially left side – reports having multiple ear infections as a child
NOSE/THROAT/LARYNX: denies dysphagia; occasional hoarseness

TEETH/MOUTH: full dentures; reports that dentures need alignment; denies soreness or bleeding of guns

CARDIAC/RESPIRATORY: no palpitations; denies shortness of breath or cough

GI: reports history of ulcers; denies any current problems or gastritis; has constipation problems and is regulated with Colace, Metamucil, MOM. Denies hemorrhoids or blood in stools

GU: denies any problems with urination

MUSCULOSKELETAL: fall 6/98 – probable compression fracture; reports mid thoracic back pain with ambulation – radiating to top of right knee. Reports some alleviation; started on Relafen for pain but currently on hold for medication noncompliance. Pain not aggravated with sitting. Denies any joint pain.

AMBULATION: uses cane to get out of chair and uses when walking outside

BALANCE/FALLS: Fall 6/98 – at risk for fall secondary to Parkinson's
Get Up and Go: Score: 13

Nursing Assessment – October, 1998
Member: Robert Jones

NEURO: Hx of Parkinson's

SLEEP: 7-8 hours per nite; denies sleepwalking; sleeping in chair

FORGETFULNESS: Rob states he if getting more forgetful with time
Depression: Rob denies depression; sad since 2nd wife died this Spring
Participant Important Issue: "I would like to get some of my eyesight back"

PHYSICAL EXAM:

RESPIRATIONS: 24 **BP**: 142/60; orthostatic B/P's; family hx of hypertension

PULSE: 76, regular

GEN'L: frail male, no acute distress w/ scant drooling from left mouth. Shuffle gait – gait is steady and gropes for objects to maintain balance. Rocks 3-4 times and uses cane to get out of chair.

SKIN: 2-3 bruises on L and R forearms. Right elbow skin tear. Pea sized scabbed area on left forearm (Rob picked at during interview). Numerous lower extremity scabs w/out erythema or drainage. Nails (toe and finger) are long. Dry skin.

EYES: PERRLA EOMI. No nystagmus. Nonecteric. Conjunctivae clear

EARS: left TM occluded with dark cerumen. Right TM well visualized with normal landmarks visible. Hearing grossly impaired.

SINUSES: nontender

ORAL: Mucosa/Dentition/Tongue: dentures upper and lower with no bleeding or lesions. Tongue pink, moist and midline
NECK/THYROID: neck supple w/out lymphadenopathy or thyromegaly. No JVD. Left Carotid buit
LUNGS: Clear to auscultation

Nursing Assessment – October, 1998
Member: Robert Jones

CARDIOVASCULAR: regular rate and rhythm without murmur; complains of muscular chest pain

PULSES: +2 radial and +1 DP

ABDOMEN: soft, nontender w/out palpable organomegaly or masses

EXTREMITIES: without cyanosis, clubbing or edema. Scabs as noted above

BACK: No vertebral or paraspinal muscle tenderness. Decreased cervical range of motion

Mood/Affect: joking
Cognition: MMS 23/27 with visual impairment
Cranial Nerves: II – XII grossly intact
Cerbellar: Romberg negative; RAM intact
Motor: 4/5 lower extremities; 4/5 upper extremities with cogwheeling of both upper and lower extremities
Reflexes: +1 bilateral and symmetric
Sensory: intact to sharp/dull sensation

RECENT LABS: Lab work pending

OTHER
Building manager: Ida
Rob reported that he "would like a beer a day" and he doesn't like chicken
Rob likes to build things like models. He also likes to walk outside.

Nursing Assessment – October, 1998
Member: Robert Jones

ASSESSMENT/PLAN:

1. Parkinson's: Continue with L-Dopa. Monitor. Consult with neuro re: increased dose to t.i.d. Neuro q 6 months. Monitor for safety in apartment and outside. Encourage use of cane. PT to evaluate assistive devices and ambulation. Family to clean apartment for garage sale this year.

2. Depression: Continue with Zoloft 50mg q a.m. Monitor effects/side effects. Provide continued support regarding grieving process or losing 2nd wife and loss of independence and eyesight

3. Probably Compression Fracture: Restart relafen 500mg q day. Monitor effect. May increase to b.i.d. prn. Activity as tolerated

4. Constipation: Continued use of bowl regime. Monitor effects

5. Vertigo: Possible benign positional vertigo versus large cerumen impaction and significant hearing loss. Plan: clean ears. Audiology exam. Monitor for safety

6. Health maintenance: Primary MD q 3-4 months. Neuro q 3-4 months. GNP monthly review and quarterly. HCRN q week and prn. Social work q month and prn. Needs Audiology, eye and dental exams. Immunizations update annually. Labs per WPP protocol.

Social Work Assessment – October, 1998
Member: Robert Jones

PRECIPITATING FACTORS:
Robert (Rob) is an 89 year old widowed man who lives alone in an apartment on the East side of Madison. His case manager Nate who works at the Blake Senior Center referred Rob to ECP. Rob was initially very resistant, to services but after a recent fall he agreed that he could use some help.

FAMILY AND MARITAL HISTORY:
Rob was born near Green Bay, WI where his mother was from. His mother came from a small family of 3 children. His father was from Glen Valley, MN. Both of Rob's parents were dairy farmers. Rob has a younger brother, Milton, who is still living in Green Bay. When Rob was 8 years old, his mom died. Rob and Milton lived with their father after that, until Rob's father remarried when Rob was 11. Rob's dad became ill shortly after that and Rob's stepmom left the family when Rob was 14. Rob took care of Milton on his own by going to school part time and working part time. Rob went through high school while working part time. He graduated two years after his class at Thompson High School in Green Bay and played basketball in his youth on a community team. Rob said that during his adult life, he has been, "up and down the ladder of wealth." Rob's first job was as a bookkeeper's assistant in a small accounting office in downtown Green Bay. Rob describes this as a wonderful experience. He met a lot of people and learned a great deal about business. He was there for several years but took a leave of absence because the accounting business during the depression the accounting office couldn't afford to keep him on. Rob describes the depression as a terrible mess. Rob met his wife, Gwenyth, during the time that he was an accounting assistant. They were married in Green Bay in 1933, shortly after they met. Rob describes their marriage as "very good." They had one child, Sharon. After leaving the accounting office, Rob sold cleaning appliances and worked part time as a janitor. He returned to school in 1938 when he was 28. Rob had to register for WWII and he almost went overseas when an automobile company hired him at the last minute. Rob said he was always sales minded. Eventually, he created his own furniture making business. His business had 20 employees, each specialized in a particular aspect of production. He sold furniture nationwide until his business went bankrupt in the late 60's due to a production problem. After this happened Rob worked doing telephone sales. He said he does not plan to ever retire. Rob reported that he still has several customers whom he sells advertising in calendars to each year. His daughter Sharon lives nearby with her husband and son, Tim. Sharon is quite close to Rob although Rob states that they do not always get along. Rob and his wife loved to travel. In 1985, when they were about to leave for a trip to Europe, his wife had a physical exam and a tumor was discovered. She died in 1987. Rob met a woman named Rose about 10 years ago and they were married in 1990. Rose died in April of 1998.

LIVING SITUATION AND CURRENT SUPPORTS:

Rob receives MOW 5x/wk for lunch. He also receives housekeeping assistance once a week from EC on Tuesday morning. Rob's grandson Tim also helps him with bathing.

Social Work Assessment – October, 1998
Member: Robert Jones

LIVING SITUATION AND CURRENT SUPPORTS (con't)
Sharon helps him with grocery shopping. Rob likes to go with her, but it is starting to be too much for him due to all the walking. Sharon also takes care of his laundry. Rob has agreed to Lifeline and a unit has been installed. Evening meals have recently been added because Rob does not seem to be eating in the evening. Home care services in the morning have also been requested

PSYCHIATRIC HISTORY:
Rob is currently being treated for depression with Zoloft. He has only been on Zoloft a short time. Rob associates his depression with his 2nd wife's death. Rob stated, "That really took me." Rob said that currently his sleep and his appetite are good. Rob said he has not cried since Rose died. Rob also stated that his mind is clear.

PREFERENCES/DESIRES:
Rob says he wants to "get back to normal so things will fall back into line." Rob knows he has to "put up with his Parkinson's disease" but he would like something done about his vision. "I was so active, it hit me like a brick. Rob said his vision is like looking through a dark, shadowy, dense fog. In September 98 he lost his driver's license completely.

FINANCIAL INFORMATION:
Rob needs the waiver to be eligible for Medical Assistance. Rob has a cost share of $290.59 in order to be eligible for the program. Rob is his own POA for finances but his grandson assists him with writing checks. Rob also has Medicare.

GENERAL HEALTH (What do you identify as your biggest concern?)
(How much alcohol do you drink weekly?)
Rob reports that his eyesight is his biggest concern. His back hurts too but he could stand that if he had his eyesight. Rob does not drink any alcohol.

COPING SKILLS:
Rob tries to think "nothing but the best." Rob tries to forget the hard stuff and keep a positive attitude. He also uses his sense of humor and is a wonderful conversationalist. He enjoys socializing and wishes he could do more.

CHURCH/SPIRITUAL INVOLVEMENT:

Rob belongs to Nazareth Church in Middleton, but said he hasn't been to church for nearly a year. This bothers him as many of his social connections are through his church. The pastor from Nazareth does come a couple of times a month to give Rob communion.

Social Work Assessment – October, 1998
Member: Robert Jones

ADVANCE DIRECTIVE:
Rob would like to develop a power of attorney for health care form with his daughter as the primary agent.

PSYCHOSOCIAL FUNCTIONS, MOOD, APPEARANCE AND COGNITION:
Rob's memory seems to be quite good. He said he would rate it between good and excellent. Rob's mood is good and he does not believe that he currently has a problem with depression. Rob is always in good spirits during our visits and very receptive to talking. Rob is always dressed in slacks and a shirt. At times there is a stale odor in the apartment or an odor of rotten food in the kitchen.

Appendix B

Situation

Edith had enrolled in the Partnership program only three months ago. Her health was deteriorating rapidly, and now there was very little she could do due to the ALS (Amyotrophic lateral sclerosis). Even raising herself to help others move her into a chair, back to bed, or onto the commode was impossible. Most of her days were spent in front of the television, sometimes sleeping, often with her gaze off to the side. Finding it difficult to communicate, her life appeared to be quite empty. Her husband of 60 years fussed over her day and night, switching to her favorite television programs, reading to her from the newspaper and getting her sips of water. He seemed to still enjoy her companionship, but looked increasingly exhausted and anxious. More and more lately, his sleep was interrupted by sounds that he interpreted as Edith choking. Her nights seemed increasingly restless and anxious.

Edith had recently developed a small skin ulcer on her cocyx and had a few other small, reddened areas. She had had a cough for a few weeks which didn't seem to be getting any better or worse. Despite eating 2 small meals a day, her weight seemed about the same. Personal care workers came in twice each day. In the mornings, the routine was to get her up to the bathroom for toileting and bathing, eat what breakfast she would, and then get her into the big chair in front of the television. In the evening, the aide would feed Edith and get in her bed. One of the aides, Lily, had been coming to Joe and Edith's home since Edith enrolled in the program. On weekends, when the aides didn't come, Joe did things himself, and it didn't always go so well. He was concerned about injuring Edith. Sometimes he bumped her into furniture and left bruises. More and more lately, he was letting her stay in bed all weekend if no one came, cleaning her up the best he could.

Someone from the program had stopped by recently to ask if he "really" needed help on the weekends, or if he could manage without it. He said he was doing okay. It was so much they were doing already and everyone was so nice. He told them that things were fine, and that he didn't need more help.

Team Meeting

When Joe and Edith were discussed at the Partnership Team Meeting, there was a split between some of the team members about what the team should focus on. Some of the team members were concerned about how exhausted Joe was, how his health seemed to be suffering, and how he might feel if something happened when he was taking care of Edith. They were focused primarily on the safety of both Joe and Edith. One of these team members suggested that a nearby nursing home would be an option for Edith and pointed out that Joe could spend all day with Edith there, staying as long as he liked. The team members knew how important it was to Joe to be with Edith.

Some other team members argued that there was no reason to <u>put</u> someone in a nursing home if the services they needed were available. These team members suggested bringing more

services into Edith and Joe's home. They asked "Isn't that the point of this program?" Some of these team members had even asked Joe about keeping Edith at home. He had expressed some anxiety over the choking and transferring, but said that he liked having her there.

Some additional information was presented at the team meeting that had filtered over from some of the personal care workers who had been to the home. One thought Joe was becoming a little strange, and that he didn't really want anyone in the house. Another one, Lily, said more personal care hours were needed. She said that Joe was always gracious to her and was very attentive to Edith.

Team Member A Perspective:

This case is a really difficult one. Edith has ALS and is terminal. She can barely do anything for herself. She chokes on her food, can't swallow pills, and is failing very quickly. Her husband really tries, but he's almost 80 and not in great health himself. Moving her into a chair, getting her to bed - these things are way too difficult for him. It isn't safe either; for either of them. They're both nervous about the transfers now. Just think what would happen if he dropped her on the floor. She should be in a nursing home. It's better for both of them. He can't tell us to do it. He'd feel too guilty. She can't communicate, but would probably feel safer with round-the-clock care. One of the nurses suggested it to him. He said 'OK'; that's okay with him. Then some of the team got together and decided that what was best for both of them was to keep her home. That's just not realistic. But he told them OK, that keeping her home was OK with him. I guess they asked him if he'd like to keep her home and he said Yes. Well, what could he say? You have to help people out sometimes. It's not fair to force him to make that decision. Telling him she needs to be in a nursing home would take the burden away and be better for everyone. He can visit all day if he wants to. Spend as much time with her as he wants to.

Team Member B Perspective

I've talked to Joe about what he and Edith want. He said he'd like to keep her home. It would be too difficult for him to get to a nursing home every day. He couldn't drive anymore and has no one around to take him there. He is worried about her safety. I know the transferring scares him. He said he'd feel better if we sent someone out to help with that. It was also quite frightening for him when she choked, just watching to be sure she was OK. Some of the team wants to put her in a nursing home, but some of us don't agree. They're not thinking about what he really wants. Joe and Edith have been together for 60 years. He would be fine with her <u>if</u> he had enough help, but there never seems to be enough help scheduled, no matter what we say. Actually, now I've just started to go by there every nite on my way home to help out.

I even gave Joe my number at home so he could call me if he needed to. I have to admit it makes me nervous when she starts choking. I haven't told the team that I'm stopping by there and talking to Joe on weekends so I don't really talk to them about Edith's choking. I can just imagine what they'd say. But some of them seem to have no idea how important this is to Joe. Every time I go, he tells me how much it means to him. I don't know how to get my teammates to understand that.

When you've finished reviewing the case study, would you please reflect on and answer following questions?

What would your goals for Edith/Joe be?

If you don't have enough information to decide what to do or to formulate goals, what other information do you need?

Why do you need this information (what is purpose of the information; what will it help you to decide?), and

Where would you get this information from?

APPENDIX C

OTHER PERSPECTIVES

***Lily's Perspective**: I've been working at Edith and Joe's house since Edith enrolled in the program, about 3 months ago. I'm not gonna lie –it's been a real handful. Edith is not doing too well and Joe is exhausted from trying to take care of her on his own. He keeps going back and forth about what to do about Edith. Fortunately, I am able to get Edith to take her pills and eat when I'm there. Recently she and I started a blinking system so we can 'talk' a little – one blink for Yes, two for No. She knows me and I know her and we communicate all right. I've tried to tell the team about Joe and how much he's struggling, but they don't seem to hear what I'm saying. My supervisor keeps telling me to let the team know what's going on, but if they won't listen to me, then what?? The team is so divided about what to do next – so nothing is happening. Some of the team thinks Edith should go to the nursing home, but others are advocating that she stay at home. No one is talking with Joe long enough to figure out where he fits. He's so grateful for the program's help that he'll agree with whatever they suggest.*

My biggest worry right now is that I don't think Edith us getting enough of her medications or enough food in her. Joe has really shied away from giving her her pills since Edith gets so agitated and starts choking. I think Edith's gotten a little fearful of Joe feeding her – sometimes he gives her her food too fast. Now he waits for me to get there to give her her medications and to feed her. She needs to eat more often and I really shouldn't be giving her the pills.

Joe's perspective:

After 50 years of marriage, I just can't believe what's happening to Edith. She clearly isn't getting better. Even though it's a terrible thing she has, the neurologist in the beginning of all of this told me that it was a very unpredictable disease. She said it's impossible to predict what might happen to Edith or when. This actually gives me hope that Edith might get better. I know she won't ever get completely better, but it would be so good if she could at least talk. And it would be great if she could stop choking. It's scary to be alone with her. The lift is too difficult to operate. I don't want to take any chances that she'll fall. What if she falls and breaks her leg or something like that and no one was here to help me? It would be awful! And it would be my fault. I know Edith wants to get up, but on weekends, when I'm alone, she has to stay in bed. I'll just stay with her.

One of the aides that comes is the same one that started when we joined Partnership. Her name is Lily and she is so much help. She's actually able to get Edith to eat and take her pills without choking. I've decided not to push Edith to eat. She doesn't seem that

interested and I can't stand the choking. As long as she's not losing weight, she probably doesn't need much food. I do worry sometimes about not giving her pills anymore. I just wait until Lily comes and have her do it, but I don't know if Edith is getting as many as she's supposed to.

Lately I've found myself thinking that she would be better in the home down the street, at least until she stops choking. I could visit her there whenever I wanted, but could also come home to sleep. I'm so tired. At the home, the nurses could feed her and give her the pills. That way I wouldn't have to worry about the choking. Edith seems to get quite agitated when I try to move her or give her her pills.

All the people from the program are so nice and helpful. But it's pretty clear to me that some of them don't think Edith should go into the home. It probably costs too much and they already do spend so much on Edith. The one who gave me her home phone number is particularly helpful – even when I just need to talk. They keep saying that they could put enough things in place to keep Edith home - that she wouldn't have to go to the nursing home. But then nothing has changed. They really seemed to think that I should be able to do the work with enough help, but I don't know if I can.

Appendix D

COMMON QUESTIONS/ISSUES CONSUMERS REPORTED ASKING/CONSIDERING WHEN EVALUATING THE QUALITY OF CARE

Team Members/Providers:

Does the person providing services to me…:

-seem to know who I am?

-make recommendations that reflect what is most important to me and/or what is happening in my life right now?

-seem knowledgeable about who is most important in my life?

-know how I get around/what I do day to day?

-know my personal medical history (including how I've reacted to certain medications/treatments, etc. in the past)?

-seem comfortable interacting with me?

-seem knowledgeable about the assistive technologies I use and/or technologies that may be useful/of benefit to me?

-seem to have some general expertise about my particular condition?

When I see a team member/provider in a care setting:

-do I have enough appointment time to interact with my provider?

-am I able to provide information to my provider that *I* think is important?

-is my provider primarily relying on/accepting information from other sources when he/she makes decisions about my care?

-do staff who assist seem experienced assisting/transferring people?

Decisionmaking about Services/Treatment Options

Am I being included in discussions and decisionmaking:

-about different service/treatment options that are available to me?

-when something in my life changes and care and services are provided to me differently than they were before the change?

-about the organization and delivery of services and how to best integrate services into my life?

Do my team members seem to share understandings about me, what's important to me, and how to provide services to me in a way that doesn't disrupt my life?

Accessibility

Are the office settings affiliated with this program accessible, including:
-reception staff who are knowledgeable about my condition and my needs when I arrive for an appointment?
-an entry way I can enter and exit freely/comfortably?
-waiting rooms accommodate my assistive technology/wheelchair?
-bathrooms that accommodate my assistive technology/wheelchair?

Are the clinical settings affiliated with this program physically accessible, including:
-reception staff who are knowledgeable about my condition and my needs when I arrive for an appointment?
-an entry way I can enter and exit freely/comfortably?
-waiting rooms accommodate my assistive technology/wheelchair?
-bathrooms that accommodate my assistive technology/wheelchair?
-lab offices with the above considerations?
-examination rooms with the above considerations?

APPENDIX E

Instructor Note: These follow-up questions should be used to explore how workshop participants in the workshop assess and plan for Rob after they are presented with the discipline specific assessments completed on Rob (Part I, Module II).

Each heading below describes a particular portion or aspect of Rob's assessments that were given to workshop participants (Appendix A). There are headers/questions that correspond to information collected in the Nursing Assessment (1-15; p38-40) and to the social work assessment (1-5; p41-42). The series of questions that follow each heading are intended to prompt discussion with team members about how their care planning around particular assessment areas (header) might impact Rob's life. For example, the nursing assessment documents that Rob has tremors. However, the assessment does not address the severity of the tremors and whether/how they affect Rob's life. The series of questions under 'Tremors' are designed to have team members think about how they assess members and the information they collect about members. The exercise is designed to assist team members to address how they think information collected during assessments can be used and who will use it.

The following assessment areas (1. – 13.) refer to the Nursing Assessment completed on Rob, in Appendix A

1. Tremors:
Do you know the severity of Rob's tremors?
(How) do the tremors affect and/or interfere with activities? How does Rob feel about that (and is this important to Rob)?
(How) does Rob control the tremors?
Can the tremors be alleviated or diminished?

2. Depression
What is the evidence for Rob's depression?
What is the diagnosis or assessment of the depression?
Is the Zoloft working? Are there side-effects?
Is medication the best approach for Rob? How does Rob feel about it?
What are other ways to deal with this?

3. Maculardegeneration
What does the loss of vision prevent Rob from doing?
What environmental changes might assist Rob?
Are there assistive technologies or other things (big numbered phone, etc..) that might help him?
What would you focus on to help Rob?
Has Rob dealt with his vision loss (i.e., what's been lost due to the loss of vision)

4. Hearing
How hard of hearing is Rob?
Has the cause of his hearing loss been assessed?
What kind of device does he use? Is it improving Rob's hearing?
Are there assistive technologies or other things that might help him?
What is combined impact of loss of vision and loss of hearing on Rob? What can you do about this?

5. Unsteady Gait/Falls
What is the cause of this?
Are there other factors that contribute to it? Are there other factors that contribute to the falls?
What impact have the falls had on Rob's life?

6. Pain
Has a pain assessment been completed?
What is the source of the musculoskeletal pain? If you can't find the source, what are you going to do about the pain?
How is the pain affecting the rest of Rob's life?

7. GI/GU
Has the cause of the constipation been determined?
Has Rob's diet been addressed?
Has exercise options been addressed?
How does the constipation affect the rest of Rob's life? Does it keep him from doing things he likes to do?

8. Dental Care
Is Rob using his dentures? What difference does it make to Rob whether or not he uses his dentures? Is that important?
Is there any link between dentures and nutritional status?

9. Medications
What does Rob have to do in order to take his medications appropriately
How/do they bother Rob? Are there any problematic medication side effects for Rob?
What is your evidence for answering Yes or No?

10 Side Effects of Medications
How do the side effects of medications affect the rest of Rob's life?
What are the consequences for Rob of the medication side effects?

Does Rob take his medications? How do you know that (what evidence leads you to believe that)

11 IADL's

Is there anything not being done (related to daily activities) that Rob would like to have done?
What social activities does Rob participate in?
What is your evidence for knowing this?
Is there anything that Rob used to do that he wants to do? (church)

12. Transportation

How is this being addressed?
How important are transportation services for Rob? What difference would they make in his life?
What is your evidence for knowing this?
Since Rob lost his driver's license, how does this relate to current nutritional needs, social relationships, etc.. What difference does the loss of the license have on Rob?

13. Equipment

Are installed handrails/grab bars useful to Rob?
What is your evidence for answering yes/no?

The following assessment areas (1. – 5.) refer to the Social Work Assessment, completed on Rob in Appendix A

1. Precipitating Factors

Why was Rob initially resistant to services? What does it mean for Rob to have to accept services? What was it about the services that he was resistant to?
What services did Rob agree to accept and are there services you are planning for Rob that he has not yet agreed to? (**Instructor:** Listen for, and address, workshop participants assumptions about Rob's need for "independence" and make distinction between *what workshop participants think* Rob needs and *what Rob thinks* he needs and wants)
Why did the fall make a difference? What connection has Rob made between the fall/s and accepting services? What help did Rob agree he could use?

2. Family and Marital History

What do you do with the information collected in the family and marital history section?
Instructor: Ask: If it is collected because it is important to listen to members tell about their lives, about who they are, that's fine. BUT then why is it shared with other team members and for what purpose? Why is it relevant or important for other team members to know this information – how do you think they should use it?
If Rob believes he's "never going to retire" what can be done with all of his skills?

3. Living Situation

Is Rob's living situation socially adequate? Is it nutritionally adequate?
What is your assessment of the personal care worker/attendant situation? What difference does the aide make in Rob's life?
Who is supervising the situation? What should the supervisor of the aide be focused on regarding the aide's work in Rob's home?
Can the personal care worker be used to report on anything that the SW needs to know?
Why isn't Rob eating in the evenings? Is this important?
What if Rob reports that he doesn't believe he's depressed – how will you address the evidence for depression that you have?

4. Preferences/Desires:

What is "back to normal" for Rob?
"I was so active" -- What are those things he "wants to get back to?" How can WPP help Rob to do this?
Do your goals reflect this?

5. Psychosocial….

Does Rob have access to decent food?
(How) does he rely on his family for social support?

What is the evidence that Rob's family is feeling overwhelmed/frustrated? Is this important to deal with? What can WPP do about it?
What is "unstable" about Rob's situation and how, specifically, will home care alter his situation? What are you basing your answer on?